		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0028787

Facility Name: Taylorville Care Center

Address: 600 South Houston (Number) Taylorville (City) 62568 (Zip Code)

County: Christian

Telephone Number: (217) 824-9636 **Fax #** (217) 824-2472

IDPA ID Number: 37-11060662

Date of Initial License for Current Owners: 08/01/1984

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL		
	Charitable Corp.		Individual		State		
	Trust		Partnership		County		
IRS Exemption Code			Corporation		Other		
		X	"Sub-S" Corp.				
			Limited Liability Co.				
			Trust				
			Other				

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2003 to 12/31/2003 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) Compilation Report Attached (Date)
(Print Name and Title) Cindy A. Tefteller, Partner
(Firm Name & Address) C.J. Schlosser & Company, L.L.C.
233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax # (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	803	56	4,140	4,999	8
9	SNF/PED					9
10	ICF	17,240	8,841		26,081	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,043	8,897	4,140	31,080	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.89%

D. How many bed-hold days during this year were paid by Public Aid?
2 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/01/1984

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/01/1984 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 16 and days of care provided 4,140

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2003 Fiscal Year: 12/31/2003

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	119,384	7,998	11,077	138,459		138,459		138,459			1
2	Food Purchase		131,958		131,958		131,958	(1,939)	130,019			2
3	Housekeeping	75,967	14,175		90,142		90,142	137	90,279			3
4	Laundry	41,879	13,134		55,013		55,013		55,013			4
5	Heat and Other Utilities			76,576	76,576		76,576	973	77,549			5
6	Maintenance	59,830	36,300	585	96,715		96,715	14,293	111,008			6
7	Other (specify):* Sanitation			5,849	5,849		5,849		5,849			7
8	**TOTAL General Services**	297,060	203,565	94,087	594,712		594,712	13,464	608,176			8
	B. Health Care and Programs											
9	Medical Director			9,698	9,698		9,698		9,698			9
10	Nursing and Medical Records	1,221,226	55,024	60,081	1,336,331		1,336,331		1,336,331			10
10a	Therapy		18	502,183	502,201		502,201		502,201			10a
11	Activities	31,524	2,148	4,858	38,530		38,530		38,530			11
12	Social Services	38,391			38,391		38,391		38,391			12
13	Nurse Aide Training											13
14	Program Transportation		1,557		1,557		1,557		1,557			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,291,141	58,747	576,820	1,926,708		1,926,708		1,926,708			16
	C. General Administration											
17	Administrative	45,869	16,817	185,000	247,686	(2,241)	245,445	(125,821)	119,624			17
18	Directors Fees											18
19	Professional Services			14,427	14,427		14,427	3,688	18,115			19
20	Dues, Fees, Subscriptions & Promotions			2,840	2,840	866	3,706	(2,161)	1,545			20
21	Clerical & General Office Expenses	26,699	20,290	11,850	58,839		58,839	48,424	107,263			21
22	Employee Benefits & Payroll Taxes			280,395	280,395	200	280,595	14,138	294,733			22
23	Inservice Training & Education			1,097	1,097		1,097		1,097			23
24	Travel and Seminar			1,314	1,314	1,175	2,489		2,489			24
25	Other Admin. Staff Transportation							1,109	1,109			25
26	Insurance-Prop.Liab.Malpractice			57,656	57,656		57,656	7,602	65,258			26
27	Other (specify):*											27
28	**TOTAL General Administration**	72,568	37,107	554,579	664,254		664,254	(53,021)	611,233			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,660,769	299,419	1,225,486	3,185,674		3,185,674	(39,557)	3,146,117			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Taylorville Care Center #0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			32,183	32,183		32,183	68,871	101,054			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes							37,613	37,613			33
34	Rent-Facility & Grounds			277,800	277,800		277,800	(277,800)				34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			309,983	309,983		309,983	(171,316)	138,667			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		103,791	9,876	113,667		113,667		113,667			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		103,791	63,531	167,322		167,322		167,322			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,660,769	403,210	1,599,000	3,662,979		3,662,979	(210,873)	3,452,106			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(349)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(1,980)	6		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,579)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(10,236)	17		18
19	Entertainment				19
20	Contributions	(500)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,073)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(1,145)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (17,862)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(193,011)	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (193,011)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (210,873)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Taylorville Care Center

ID# 0028787

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Record 2003 IDPH License Paid in 2002	$ 200	20	1
2	Chamber of Commerce Dues	(359)	17	2
3	Vending Machine Cost	(11)	2	3
4	Record Defered Maintenance Costs	626	6	4
5	Eliminate 2004 Computer Maint. Fees Paid in '03	(2,373)	6	5
6	Offset Tax Refund	(252)	22	6
7	Depr. On items required to be capitalized for cost rpt	1,218	30	7
8	Offset Insurance Refund	(194)	26	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(1,145)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,939)	0	0	0	0	0	0	0	0	0	0	(1,939)	2
3	Housekeeping	0	137	0	0	0	0	0	0	0	0	0	137	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	973	0	0	0	0	0	0	0	0	0	973	5
6	Maintenance	(3,727)	18,020	0	0	0	0	0	0	0	0	0	14,293	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(5,666)	19,130	0	0	0	0	0	0	0	0	0	13,464	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(10,595)	(115,226)	0	0	0	0	0	0	0	0	0	(125,821)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	3,688	0	0	0	0	0	0	0	0	0	3,688	19
20	Fees, Subscriptions & Promotions	(2,373)	212	0	0	0	0	0	0	0	0	0	(2,161)	20
21	Clerical & General Office Expenses	0	48,424	0	0	0	0	0	0	0	0	0	48,424	21
22	Employee Benefits & Payroll Taxes	(252)	14,390	0	0	0	0	0	0	0	0	0	14,138	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	1,109	0	0	0	0	0	0	0	0	0	1,109	25
26	Insurance-Prop.Liab.Malpractice	(194)	2,676	5,120	0	0	0	0	0	0	0	0	7,602	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(13,414)	(44,727)	5,120	0	0	0	0	0	0	0	0	(53,021)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(19,080)	(25,597)	5,120	0	0	0	0	0	0	0	0	(39,557)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	1,218	5,253	62,400	0	0	0	0	0	0	0	0	68,871	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	711	36,902	0	0	0	0	0	0	0	0	37,613	33
34	Rent-Facility & Grounds	0	0	(277,800)	0	0	0	0	0	0	0	0	(277,800)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	1,218	5,964	(178,498)	0	0	0	0	0	0	0	0	(171,316)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,862)	(19,633)	(173,378)	0	0	0	0	0	0	0	0	(210,873)	45

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerry & Marilyn King	100.00	K & G Inc., d/b/a Mt. Vernon Countryside Manor	Mt. Vernon	King Management	Nashville	Home Office
Jerry & Marilyn King	100.00	Aviston Nursing Center, Inc. d/b/a Countryside Manor	Aviston			
Jerry & Marilyn King	100.00	King Mangement, Inc., d/b/a Nokomis Golden Manor	Nokomis			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	See Schedule VIII	$	King Management Co.	100.00%	$ 137	$ 137	1
2	V	5	See Schedule VIII		King Management Co.	100.00%	973	973	2
3	V	6	See Schedule VIII		King Management Co.	100.00%	18,020	18,020	3
4	V	17	See Schedule VIII	185,000	King Management Co.	100.00%	69,774	(115,226)	4
5	V	19	See Schedule VIII		King Management Co.	100.00%	3,688	3,688	5
6	V	20	See Schedule VIII		King Management Co.	100.00%	212	212	6
7	V	21	See Schedule VIII		King Management Co.	100.00%	48,424	48,424	7
8	V	22	See Schedule VIII		King Management Co.	100.00%	14,390	14,390	8
9	V	25	See Schedule VIII		King Management Co.	100.00%	1,109	1,109	9
10	V	26	See Schedule VIII		King Management Co.	100.00%	2,676	2,676	10
11	V	30	See Schedule VIII		King Management Co.	100.00%	5,253	5,253	11
12	V	33	See Schedule VIII		King Management Co.	100.00%	711	711	12
13	V								13
14	Total			$ 185,000			$ 165,367	$ * (19,633)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent - Facility & Grounds	$ 277,800	Jerry & Marilyn King	100.00%	$	$ (277,800)	15
16	V	26	Insurance		Jerry & Marilyn King	100.00%	5,120	5,120	16
17	V	30	Depreciation		Jerry & Marilyn King	100.00%	62,400	62,400	17
18	V	33	Real Estate Taxes		Jerry & Marilyn King	100.00%	36,902	36,902	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 277,800			$ 104,422	$ * (173,378)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Jerry King	Owner	Mgmt/Consultant	100.00	56,076	15	26.02%	Salary	$ 19,722	17,8	1
2	Denise King	Regional Director	Administrative	0.00	130,748	15	26.02%	Salary	45,985	17,8	2
3	Keith King	Maint. Supervisor	Maintenance	0.00	43,616	13	26.02%	Salary	15,340	6,8	3
4	Leslie Pedtke	Administrator	Administrative	0.00	99,564	0	0.00	Salary	0	17,1	4
5	Elizabeth King	Dietary	Dietary	0.00	2,496	0	0.00	Salary	0	1,1	5
6	Marilyn King	Owner	Mgmt/Consultant	100.00	2,959	1	26.02%	Salary	1,041	17,8	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 82,088		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: King Management Company, Inc.
Street Address: 935 South Mill Street
City / State / Zip Code: Nashville, IL 62263
Phone Number: (618) 327-3064
Fax Number: (618) 327-3083

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	119,399	4	$ 525	$ 525	31,067	$ 137	1
2	5	Utilities	Patient Days	119,399	4	3,738		31,067	973	2
3	6	Maintenance	Patient Days	119,399	4	69,255	58,956	31,067	18,020	3
4	17	Administrative	Patient Days	119,399	4	268,160	256,531	31,067	69,774	4
5	19	Professional Fees	Patient Days	119,399	4	14,175		31,067	3,688	5
6	20	Dues, Fees & Subscriptions	Patient Days	119,399	4	813		31,067	212	6
7	21	Clerical and Office Expense	Patient Days	119,399	4	186,105	131,685	31,067	48,424	7
8	22	Employee Benefits	Patient Days	119,399	4	55,304		31,067	14,390	8
9	25	Other Admin. Staff Transport	Patient Days	119,399	4	4,263		31,067	1,109	9
10	26	Insurance	Patient Days	119,399	4	10,283		31,067	2,676	10
11	30	Depreciation-Vehicles	Patient Days	119,399	4	8,733		31,067	2,272	11
12	30	Depreciation-Other	Patient Days	119,399	4	11,457		31,067	2,981	12
13	30	Depreciation-Copier	Direct Cost	1	1	679		0	0	13
14	33	Real Estate Taxes	Patient Days	119,399	4	2,732		31,067	711	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 636,222	$ 447,697		$ 165,367	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Schedule Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	36,200	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	36,902	2
3. Under or (over) accrual (line 2 minus line 1).	$	702	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	36,200	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	36,902	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	33,080	8
	1999	33,015	9
	2000	34,482	10
	2001	35,441	11
	2002	36,902	12

Line 2: Real Estate Taxes paid are for the 2002 tax year.

Line4: Accrual is based on the 2002 taxes paid.

Line7: $36,902 Real Estate Tax
711 Home office allocation
$37,613 Total Real Estate Tax Schedule V, Line 33

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Taylorville Care Center COUNTY Christian

FACILITY IDPH LICENSE NUMBER 0028787

CONTACT PERSON REGARDING THIS REPORT Linda Peppenhorst

TELEPHONE (618) 327-3064 FAX #: (618) 327-3083

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	17-13-28-401-005	Cheneys Add Lts 1 thru 6 Blk 3 &	$ 36,760.40	$ 36,760.40
2.		Lts 1 thru 6 Blk 4 & OL 1 & Vac	$	$
3.		Austin St & Alley	$	$
4.	17-13-28-401-006	N1/2 S 1/2 NW SE EX E440	$ 141.80	$ 141.80
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 36,902.20	$ 36,902.20

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,610 B. General Construction Type: Exterior Brick Frame Non-Comb. Sprinkle Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Taylorville Estates is a 39 unit (27,945 square foot) retirement center which is located on the property adjacent to Taylorville Care Center

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	98 Bed Nursing Home	186,200	1984	$ 40,000	1
2	Home Office Land		1989	1,637	2
3	TOTALS	186,200		$ 41,637	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1984	1974	$ 1,560,000	$	25	$ 62,400	$ 62,400	$ 1,217,017	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	80 Gallon Water Fixture			1985	1,581		10			1,581	9
10	Improvements to Building			1985	12,510	500	25	500		9,009	10
11	Improvements to Parking Lot			1986	1,184		10			1,184	11
12	New Light Fixtures			1987	997		10			997	12
13	Tile Floor			1987	5,941	142	10		(142)	5,941	13
14	Roof			1988	55,100		10			55,100	14
15	Addition to Alarm System			1988	5,610		10			5,610	15
16	Concrete Driveway			1989	2,729	182	15	182		2,668	16
17	Nurses Station			1991	4,809		15	321	321	4,061	17
18	Water Heater			1993	3,750	250	15	250		2,708	18
19	Air Conditioner			1993	2,800	163	10	163		2,799	19
20	New Office			1993	1,500	38	40	38		376	20
21	4" Backflow Preventer			1994	3,966	159	25	159		1,587	21
22	Carpeting			1994	2,471	247	10	247		2,306	22
23	Circulating Pump on Water Heater			1994	2,450	175	14	175		1,619	23
24	Fence			1995	3,590	239	15	239		2,054	24
25	Water Heater			1995	1,602	107	15	107		953	25
26	Sprinkler Heads			1995	1,600	107	15	107		863	26
27	New Roof			1996	25,000	2,500	10	2,500		18,542	27
28	Water Softener			1996	5,908	492	12	492		3,610	28
29	Ceramic Tile			1997	5,167	517	10	517		3,574	29
30	Garage			1997	7,841	784	10	784		5,097	30
31	Rooftop A/C, Ducts & Gas Lines			1997	10,940	1,094	10	1,094		7,111	31
32	Beauty Shop Addition			1997	6,823	455	15	455		2,729	32
33	Carpet			1998	4,154	415	10	415		2,353	33
34	Windows			1998	5,681	568	10	568		3,124	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heating & A/C Units	1998	$ 4,128	$ 619	5	$ 619	$	$ 4,128	37
38	Air Conditioner Units	1999	25,051	2,505	10	2,505		11,482	38
39	Rear Parking Lot/Driveway	1999	2,995	300	10	300		1,273	39
40	Air Conditioner Units	2000	4,834	483	10	483		1,611	40
41	Landscaping	2001	2,300	230	10	230		537	41
42	Electrical	2001	6,725	672	10	672		1,905	42
43	Cabinets	2001	27,445	1,372	20	1,372		3,773	43
44	Water Heater	2001	5,800	387	15	387		967	44
45	Wallpaper & Installation	2002	9,016	1,803	5	1,803		3,005	45
46	Wallguards	2002	5,729	382	15	382		668	46
47	Water Heater	2002	6,759	451	15	451		564	47
48	Carpet/Baseboard Remodel	2002	16,561	1,656	10	1,656		2,898	48
49									49
50	Home Office Parking Lot	1989	514		10			514	50
51	Home Office Building	1995	25,507		25	1,020	1,020	8,332	51
52	Home Office Interior Finishes Lower Level	1996	1,582		15	105	105	791	52
53	Home Office Carpet	1996	553		5			553	53
54	Home Office Cabinets	1996	875		20	44	44	328	54
55	Home Office Electrical	1996	303		15	20	20	152	55
56	Home Office Front Door	2002	416		10	42	42	52	56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,892,797	$ 19,994		$ 83,804	$ 63,810	$ 1,408,106	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 96,797	$ 9,215	$ 11,499	$ 2,284	5-10 Yrs	$ 75,046	71
72	Current Year Purchases	15,859	2,550	3,055	505	5 Yrs	3,055	72
73	Fully Depreciated Assets	256,372					256,372	73
74								74
75	TOTALS	$ 369,028	$ 11,765	$ 14,554	$ 2,789		$ 334,473	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Home Office Vehicle	2002 Ford F150 P/U	2002	$ 3,691	$	$ 923	$ 923	4	$ 1,538	76
77	Facility Business	1994 Chevy Van	1995	13,590				4	13,590	77
78	Facility Business	2003 Ford Supreme Bus	2003	20,375	424	424		4	424	78
79	Home Office Vehicle	2004 Lexus RX 330	2003	10,796		1,349	1,349	4	1,349	79
80	TOTALS			$ 48,452	$ 424	$ 2,696	$ 2,272		$ 16,901	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,351,914	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,183	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,054	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 68,871	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,759,480	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Section Not Applicable	$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Section Not Applicable	$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Section Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? N/A YES N/A NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Section Not Applicable		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a,3	hrs	$	11,397	$ 233,614	$	11,397	$ 233,614	1
2	Licensed Speech and Language Development Therapist	10a,3	hrs		2,846	66,849		2,846	66,849	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a,3	hrs		10,587	201,720		10,587	201,720	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39,2	# of prescrpts				103,791		103,791	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Lab, X-Ray & Amb.	39,3				9,876			9,876	13
14	TOTAL			$	24,830	$ 512,059	$ 103,791	24,830	$ 615,850	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2003 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 524,700	$	1
2	Cash-Patient Deposits	8,212		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,894)	621,216		3
4	Supply Inventory (priced at)	5,032		4
5	Short-Term Investments	136,056		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,295,216	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost	230,512		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	375,050		16
17	Accumulated Depreciation (book methods)	(437,146)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	12,165		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(12,165)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 168,416	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,463,632	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 193,403	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	8,212		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	125,999		30
31	Accrued Taxes Payable (excluding real estate taxes)	15,161		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due to Related Parties	2,260		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 345,035	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 345,035	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,118,597	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,463,632	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 899,755	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 899,755	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	399,138	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(175,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Prior Year IL Replacement Tax Adj.**	(5,296)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 218,842	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,118,597	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,693,849	1
2	Discounts and Allowances for all Levels	(391,016)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,302,833	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	742,421	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 742,421	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	8,635	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 8,635	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,299	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,299	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Diaper Charges	1,955	28
28a	Miscellaneous	4,974	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 6,929	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,062,117	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	594,712	31
32	Health Care	1,926,708	32
33	General Administration	664,254	33
	B. Capital Expense		
34	Ownership	309,983	34
	C. Ancillary Expense		
35	Special Cost Centers	113,667	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,662,979	40
41	**Income before Income Taxes (line 30 minus line 40)****	399,138	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 399,138	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** **SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,033	2,212	$ 49,296	$ 22.29	1
2	Assistant Director of Nursing	1,529	1,649	27,135	16.46	2
3	Registered Nurses	8,318	8,628	141,196	16.36	3
4	Licensed Practical Nurses	20,640	21,840	296,365	13.57	4
5	Nurse Aides & Orderlies	67,281	69,212	687,424	9.93	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,685	3,808	31,524	8.28	10
11	Social Service Workers	3,691	3,871	38,391	9.92	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,181	17,015	119,384	7.02	15
16	Dishwashers					16
17	Maintenance Workers	3,923	4,252	59,830	14.07	17
18	Housekeepers	9,532	14,047	75,967	5.41	18
19	Laundry	6,345	6,748	41,879	6.21	19
20	Administrator	1,970	2,190	45,869	20.94	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,609	2,738	26,699	9.75	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,939	2,049	19,810	9.67	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	149,676	160,259	$ 1,660,769 *	$ 10.36	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	196	$ 10,394	1,3	35
36	Medical Director	Contract	9,698	9,3	36
37	Medical Records Consultant	18	1,140	10,3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Contract	980	10,3	39
40	Physical Therapy Consultant	179	8,934	10,3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	86	4,858	11,3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	479	$ 36,004		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	36	$ 1,753	10,3	50
51	Licensed Practical Nurses	1,490	44,604	10,3	51
52	Nurse Aides	147	2,670	10,3	52
53	TOTAL (lines 50 - 52)	1,673	$ 49,027		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jacqueline Carpenter	Administrator	0	$ 45,869
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 45,869

B. Administrative - Other

Description	Amount
Management Fees	$ 185,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 185,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
C.J. Schlosser & Company	Accounting	$ 10,125
Greensfelder, Hemker & Gale	Legal	4,302
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 14,427

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 97,483
Unemployment Compensation Insurance	36,502
FICA Taxes	128,297
Employee Health Insurance	15,216
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Pension Expnse	846
Home Office Allocation	14,390
Employee Chirstmas Party	200
Employee Physicals	1,800
TOTAL (agree to Schedule V, line 22, col.8)	$ 294,734

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
Section Not Applicable		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	267
Health Care Worker Background Check	
(Indicate # of checks performed 32)	384
Subscriptions	482
Home Office Dues & Subscriptions	212
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,545

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,489
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,489

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Taylorville Care Center # 0028787 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Wallpapering	02/2002	$ 1,878	3 YRS	$	$	$ 522	$ 626	$ 626	$ 104	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 1,878		$	$	$ 522	$ 626	$ 626	$ 104	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Taylorville Care Center **#** 0028787 **Report Period Beginning:** 01/01/2003 **Ending:** 12/31/2003

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **3,713** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,655**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **None**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **349**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **58%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

TAYLORVILLE CARE CENTER
RECLASSIFICATIONS
12/31/03

DESCRIPTION	SCHED V LINE #		INCREASE (DECREASE)
FEES & SUBSCRIPTIONS	20		866
EMPLOYEE BENEFITS & PAYROLL TAXES	22		200
SEMINARS & TRAVEL	24		1,175
ADMINISTRATIVE	17		(2,241)
TO RECLASS THE FOLLOWING EXPENSES RECORDED IN MISCELLANEOUS EXPENSE TO THE CORRECT LINES:			
BACKGROUND CHECKS		$384	
MISC DUES & LICENSES		482	
EMPLOYEE PARTY		200	
SEMINARS		1,175	
TOTAL		2241	